

# **CROWD OUT AND PUBLIC/PRIVATE SUBSTITUTION**

## **Summary of Relevant Literature<sup>1</sup>**

### Overview

Traditionally, the term “crowd-out” refers to the substitution of public for private insurance; a phenomenon in which insurance purchased with private dollars (whether by individuals or employers) is substituted by insurance purchased (or subsidized) by public dollars. Crowd-out is a major concern in designing new or expanded public programs to address the uninsured, because it is perceived as an inefficient or wasteful use of public funds. Moreover, the actual costs of extending health insurance coverage to the currently uninsured increase as crowd-out increases, reducing the effectiveness of government expenditures.

“Crowd-out” can actually be viewed as consisting of several different processes, and disentangling them is important to understanding how to prevent them. Substitution may occur as a result of actions by individuals/families, employers, or both. Ironically, individuals may be penalized by policies that attempt to prevent crowd-out, for example, if they have been dropped from an employer’s coverage because public funds have become available.<sup>2</sup>

One of the most challenging aspects of designing or expanding public programs is striking the right balance between “take-up” and “crowd-out.” Legislation authorizing SCHIP programs mandates that states design policies to reduce crowd-out; however, it is not known how much of a difference in insurance coverage such policies can be expected to make. While there is empirical evidence about the nature and extent of crowd-out, concerns recently have been raised about whether the existing literature, as it stands, is capable of providing adequate answers.<sup>3</sup> The purpose of this paper is to summarize the existing literature regarding crowd-out, and to present some of the current thinking about how to define and measure crowd-out, including policy implications. Further, the paper includes a brief discussion of how crowd-out is treated in recent proposals for expansion of health insurance.

### Evidence Regarding Crowd-out

A number of researchers have attempted to estimate crowd-out effects, most commonly by examining the Medicaid expansions for children and pregnant women enacted in the 1980s and early 1990s. Due to various assumptions, samples, and analytical decisions,

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<sup>1</sup> This report was prepared for the Illinois Department of Insurance State Planning Grant by Jane L. Swanson, Southern Illinois University at Carbondale. Policy implications are excerpted from Alteras (2001).

<sup>2</sup> Shore-Sheppard, 2000.

<sup>3</sup> Alteras, 2001; Swartz, 1996.

the estimates of crowd-out vary considerably, ranging from 15% to 50%, even within the same data set by asking somewhat different questions.<sup>4</sup>

The most frequently cited study used CPS data from 1988 to 1993 to describe three ways of estimating crowd-out: (1) the decrease in private coverage as a share of the individuals who became eligible for Medicaid after the expansions, (2) the decrease in private coverage as a share of total increase in Medicaid enrollment, and (3) the percentage decline of private coverage over time that can be attributed to Medicaid enrollment. Crowd-out was estimated at 50%, 22%, and 15%, respectively, using these three different measures. The lower estimates, in effect, account for factors other than Medicaid that might influence the shift away from private to public insurance; the lowest rate of 15% is the most direct measure of substituting Medicaid for private insurance.<sup>5</sup> However, the 50% rate frequently is cited by policymakers as rationale for making crowd-out provisions more stringent.<sup>6</sup>

A second study using CPS data came to somewhat different conclusions, by examining two separate populations: children from families with incomes below 100% FPL, and children from families with incomes between 100% and 133% FPL. A control group consisted of single men in the same income ranges. The researchers estimated that 14% of pregnant women and 17% of children who enrolled in Medicaid had been eligible for private insurance. The rates were higher, however, for individuals above the 100% FPL: they estimated that 45% of pregnant women and 21% of children who became eligible for Medicaid following the expansions dropped their private insurance to enroll in Medicaid.<sup>7</sup>

A third study based on CPS data (from 1988, 1993, and 1996) resulted in similar estimates: 15% for the period 1988-1993, and 30% for 1988-1996.<sup>8</sup> In all three of these studies, researchers are challenged to disentangle changes in private insurance that occur for reasons other than Medicaid expansion, using data that were not designed to answer these questions.

In addition to the three studies based on national data, one study used state-level data to examine crowd-out. Specifically, families with children enrolled in Florida's SCHIP program were surveyed on their insurance coverage prior to enrolling in the program: 26% had access to employer-sponsored insurance, but only 5% had been enrolled prior to entering SCHIP. On average, enrollment in employer-based dependent coverage required a premium payment of 13% of their income, which could prohibitively expensive for low-income workers.<sup>9</sup>

Three studies used longitudinal data to examine questions of crowd-out. The previously cited studies used cross-sectional data, which provides snapshots of insurance coverage at

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<sup>4</sup> Cutler & Gruber, 1996; Shore-Sheppard, 1997, as cited in Yazici & Kaestner, 1998, 2000.

<sup>5</sup> Cutler & Gruber, 1996.

<sup>6</sup> Swartz, 1996.

<sup>7</sup> Dubay & Kenney, 1996.

<sup>8</sup> Shore-Sheppard, 1997, as cited in Yazici & Kaestner, 1998, 2000.

<sup>9</sup> Shenkman *et al.*, 1999, as cited in Alteras, 2001.

several different times; however, cross-sectional studies do not allow direct examination of change over time. In contrast, longitudinal studies offer the advantage of examining the same individuals over time, thus measuring changes in insurance status more directly.

Two studies examined data from the National Longitudinal Survey of Youth (NLSY). In the first, changes between 1990 and 1994 indicated that the majority of new Medicaid enrollees were uninsured during the year prior to enrollment, and only 16% of newly enrolled children had access to private insurance at the time of enrollment.<sup>10</sup> The second NLSY study examined four-year data beginning in 1988, and estimated crowd-out by comparing a group of children who became eligible due to Medicaid expansions to control groups of children who either always were eligible or never eligible. Estimates ranged from 0% to 33%, with an average of 19%.<sup>11</sup>

A third longitudinal study analyzed Survey of Income and Program Participation (SIPP) data beginning in 1990. Results suggested that 23% of movement into Medicaid from private coverage was due to crowd-out; this estimate was lowered to 4% when all movement into Medicaid was considered.<sup>12</sup>

In addition to evidence based on analysis of large cross-sectional or longitudinal data sets, several researchers have used case study or survey data to address issues of crowd-out. A survey of employers and employees about their knowledge of SCHIP found that 19% of employers would consider dropping dependent coverage due to SCHIP; employers with low-wage workers were most likely to consider dropping coverage.<sup>13</sup> Given that dependent coverage is likely to be prohibitively expensive (and that SCHIP may provide better coverage), an employer's decision to drop coverage is considered by some analysts as a benefit rather than as "crowd-out."<sup>14</sup> The percentage of employers who would consider dropping coverage, however, was substantially lower when informed that employees' children would face a waiting period before becoming eligible for SCHIP coverage.<sup>15</sup>

Finally, a study combining CPS data with firm-level data supplied by the Health Insurance Association of America (HIAA) concluded that Medicaid expansions did not lead firms to drop health insurance or change employees' portion of premiums. Increased take-up of Medicaid thus was more likely due to decisions made by individual employees rather than by employers.<sup>16</sup>

Legislatures and researchers have put considerable effort into estimating crowd-out, but determining causal relationship between a given public program and changes in insurance enrollment is not straightforward. The primary disadvantage of using data from earlier

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<sup>10</sup> Thorpe & Florence, 1998.

<sup>11</sup> Yazici & Kaestner, 1998, 2000.

<sup>12</sup> Blumberg, Dubay, & Norton, 2000. The estimate dropped from 23% to 4% because the higher estimate was based only on those individuals who were privately insured prior to Medicaid enrollment, whereas the lower estimate was based on total new Medicaid enrollment.

<sup>13</sup> Meyer *et al.*, 1999, as cited in Alteras, 2001.

<sup>14</sup> Alteras, 2001.

<sup>15</sup> Meyer *et al.*, 1999

<sup>16</sup> Shore-Sheppard, Buchmueller, & Jensen, 2000.

Medicaid expansions is that such data preclude researchers' ability to examine some of the more complex questions about crowd-out, such as the effects of premium costs, benefits, provider networks, etc., on substitution. Measuring the effects of expansions on crowd-out is more important than ever, but must account for difficult-to-measure variables, including: whether people moved directly from private insurance into Medicaid; whether they intentionally disenrolled from private coverage or lost through change in employment, loss of income, or other factors; whether they've had consistent coverage over 12-month period; and, whether benefits offered through Medicaid/SCHIP were broader, more stable, and/or more affordable than those available through private coverage.

### Policy Implications

Policymakers and researchers are beginning to understand that complex questions underlie estimates of crowd-out. A consideration of the policy implications of crowd-out raises many questions: How much crowd-out is acceptable in a public program? What policy measures are effective at controlling crowd-out? Are all rationales for substituting public for private coverage equal when determining a program's cost-effectiveness? How might policymakers rank the priorities of efficiency and equity to improve health status?<sup>17</sup>

Concern about crowd-out were prominent during the Medicaid expansions in the 1980s and early 1990s, yet recent efforts to expand SCHIP eligibility or waivers to subsidize employer-based coverage have fueled the concern. These recent efforts add to the complexity associated with monitoring crowd-out: The higher the income eligibility for SCHIP, and, the greater the possibility of interaction between public and private insurance markets (through buy-ins), the greater potential for (and more difficult it will be to measure) crowd-out.

When the SCHIP program was first signed into law in 1997, analysts predicted that it would lead to individuals dropping out of private insurance. In addition, there were further concerns that employers who offered coverage and employed a high percentage of low-income workers would either drop coverage or make it more expensive in order to encourage public enrollment. These concerns highlight the fact that well-intentioned public policy may create perverse incentives that could ultimately undermine the goal of policy.

Moreover, assessing the policy implications of crowd-out is not as straightforward as might first appear. "Crowd-out" is perceived in negative terms, as misuse of limited public resources. However, the "costs" of crowd-out also may have important benefits. For example, low-income workers who choose to substitute public coverage for private health insurance may do so because the public program offers access to continuous, comprehensive health care that they could not otherwise afford. Further, in some cases, the "cure" for crowd-out may be worse than the disease: Policies that deny coverage to those who have been privately insured in the past often leave many currently uninsured

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<sup>17</sup> Alteras, 2001.

without health care, including those that have lost jobs or been dropped from employer's plan because public funds became available.

One of the problems in defining crowd-out is that there are many reasons why individuals or families might drop private health coverage to enroll in publicly funded programs, yet all instances are subsumed under the single term of "crowd-out." Additional terms have been offered to help clarify the distinction. The two primary distinctions are "opt-out" when substitution is initiated by the individual, because he or she is choosing to leave a private program to enroll in a public program, and "push-out" when an employer ceases to offer group coverage or raises cost-sharing to unaffordable levels knowing workers may be eligible for public programs.<sup>18</sup>

There are at least four different types of scenarios that may or may not be defined as crowd-out. The first is substituting public coverage for non-group coverage, such as when parents drop a child from their non-group private coverage to enroll them in SCHIP. Many families buying non-group coverage do so because their children have special needs, yet this private coverage is likely to be achieved at prohibitive cost. Should this be considered crowd-out? The second scenario is substituting public coverage for group coverage, which may mask more complicated issues, given the interaction between an employer's and employee's decision-making behavior. For example, low-wage workers who drop high-premium dependent coverage, versus an employer with many SCHIP-eligible employees who decides to drop dependent coverage (or employer-based coverage altogether). Should both of these choices be considered crowd-out? The third scenario include substitutions that are driven by specific benefit, with the underlying issue of how private benefits packages motivate public enrollment. For example, a pregnant woman might drop a catastrophic private plan that does not cover pregnancy or delivery to enroll in a public program that does include such benefits. While this example would be considered crowd-out, the woman's decision clearly avoids the high public costs associated with not having coverage in the private plan. Finally, the fourth scenario is maintaining a child's enrollment in public coverage after a parent's change in employment. One of the characteristics of the Medicaid/SCHIP-eligible population is unstable employment, and so it is not uncommon for children in public programs to have access to private coverage for various periods. Given the instability in access to insurance, though, it makes sense from an economic and public health perspective to let children remain enrolled in public. Should this be considered crowd-out?<sup>19</sup>

These scenarios illustrate the difficulty in designing public programs, and why it is important to understand why shifts in insurance occur. Moreover, understanding these shifts in coverage is particularly important in designing strategies for limiting crowd-out; strategies must be appropriate to the behavior they're trying to control. Each policy option carries specific incentives for either employer or individual, and policymakers need to be mindful of whose behavior will be affected, and of the impact on other facets of the private and public health care market.

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<sup>18</sup> Alteras, 2001.

<sup>19</sup> Alteras, 2001.

Strategies to inhibit crowd-out can be classified as direct or indirect. Direct strategies attempt to address enrollee behavior (“opt-out”) by making public program appear less attractive to target population, through eligibility restrictions based on current insurance status or time spent uninsured, and/or mandatory premium contributions. Indirect strategies seek to encourage employers to begin or continue offering accessible and affordable benefits for families and dependents, thereby making private options attractive for those eligible for public (limiting “push out”). Indirect strategies include subsidizing employees to make private premiums more affordable, establishing purchasing cooperatives for small businesses, reimbursing firms for purchase of employer-based coverage, and establishing employer tax credits to encourage employers to offer benefits or deduct the cost of premium payments.

### How Are Concerns about Crowd-out Addressed in Recent Proposals?

There will always be a trade-off between increasing participation (take-up) while avoiding unnecessary substitution (crowd-out), and recent proposals include discussion of how to achieve a balance between the two processes.

Recent proposals focusing on health insurance tax credits contain features that may diminish the seriousness of crowd-out threat. First, some proposals adjust the amount of the tax credit by age and sex, which means there will be little incentive for young, healthy, males to leave employer-based insurance. Second, in most cases, employer-based coverage represents significant cost savings over the non-group coverage that would be purchased using the tax credits. Third, phaseout of the tax credit at higher levels of income will reduce the amount of subsidy for many workers. Fourth, some proposals exclude individuals who already have coverage – whether through employers (for proposals that focus on employer-based coverage) or from the non-group market (for proposals using this route to insurance coverage).

Some programs more likely to generate crowd-out problems than others. For example, pooled purchasing arrangements targeted to low-wage small businesses may be less prone to crowd-out because most of these employers do not sponsor coverage; those that do are very likely to drop coverage as premiums or circumstances change.<sup>20</sup> Expansions to cover the parents of CHIP-eligible children also may be relatively unaffected by crowd-out, given that parents of low-income children are unlikely to be insured.<sup>21</sup> However, the potential of crowd-out will increase as the level of income eligibility increases.

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<sup>20</sup> Curtis, Neuschler, & Forland, 2000.

<sup>21</sup> Lambrew, 2001.

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